

Emotions, interaction and the injured sporting body

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Abstract

Based upon a collaborative autoethnographic research project, this article explores from a sociological perspective the emotional dimension of the injured sporting body. It takes as its analytic focus the journey, rehabilitative, emotional and narrative, of two middle-aged, non-élite, middle/long-distance runners who encountered serious, long-term knee injuries. The paper examines in particular the interactional and narrative elements of the rehabilitative journey, focussing on dimensions of the emotion management, emotion work, and emotional intersubjectivity of the researcher/author and her training partner as they struggled to contend with the liminality of the injured athletic role, and to maintain positive identities in the face of serious threat to their running selves.

Key words: sports injury; emotions; autoethnography

Biographical note

Jacquelyn Allen Collinson is a Research Fellow in the Leisure & Sport Research Unit at the University of Gloucestershire, UK. Her previously published work includes research on occupational socialisation and identities, and current projects cohere around the sociology of the sporting body; women and distance-running; and the use of ethnography and autoethnography.

Since the 1970s, and the groundbreaking work of Arlie Hochschild (1975), there has been a burgeoning literature in the sociology of emotions (Barbalet, 2002), which now constitutes a flourishing sub-area (Williams, 2001; Shilling, 2002), and includes work on the development of sociological theories of sport and the emotions (eg. Maguire, 1991). There are a variety of different approaches covering a range of theoretical perspectives, and employing different methodologies (Hochschild, 1998). The role of emotions has been studied in relation to family and intimate relationships (Hochschild, 1989; Chin, 2000; Karp & Tanarugsachock, 2000; Reay, 2000), and to a range of occupational contexts, such as: flight attendants (Hochschild, 1983); a volunteer search and rescue group (Lois, 2001); and criminal investigators and bill collectors (Rafaeli & Sutton, 1991).

Analogous to the development of the sociology of emotions, there is a growing body of psychological and sociological literature on sports injuries (Wiese-Bjornstal *et al*, 1998). Athletes' emotional responses to injury have been described by a number of psychologically-oriented researchers, as documented by Wiese-Bjornstal *et al* (1998: 52), and there is also recent work in sport philosophy (McNamee, 2002). From a sociological perspective, researchers of a variety of methodological persuasions have examined varied factors influencing response to injury, including *inter alia* socialisation processes (Curry, 1993), gender (Messner, 1992; Young, White & McTeer, 1994; Young & White, 1995), the cultural milieu of specific sports (Frey, 1991; Shaffer, 1996; Krane, Greenleaf & Snow, 1997; Howe, 2003), the influence of social networks and support (Nixon, 1992; Johnston & Carroll, 2000), and athletes' attitudes toward injury and risk-taking (Young & White, 1995; Pike & Maguire, 2003). A relatively recent development has been the autoethnographic turn in the analysis of sporting injury (eg. Denison, 1999; Allen Collinson & Hockey, 2001, Sparkes, 2003) and the distinctive contribution of autoethnography to the field is considered below.

The complexity of emotions, and the difficulty in defining precisely what an emotion is, have preoccupied many (see for example, Ben-Ze'ev, 2000). For the purposes of this paper, and following Denzin (1984: 3), I employ the term emotions to describe self-feelings as an *embodied* form of consciousness. As Cassell has noted, 'Emotions – emotional feelings – are always felt physically, from apathy to joy, and anger to fear. Bodily sensation is an eradicable aspect of emotion...' (2001: 376). While acknowledging the biological, 'natural' dimensions of emotion which interweave with the social to produce embodied emotion (Elias, 1991), the paper focuses on social interactional concerns, in particular the dimensions of the emotion management, emotion work and emotional intersubjectivity of two distance runners who suffered very similar experiences of relatively long-term knee injuries. As others have noted (Pike & Maguire, 2003), in order to understand emotional responses to the injured athletic body, it is necessary to consider such responses in the interactional context.

This paper contributes new perspectives to the sociological literature on the subjective experience of sporting injury, via an *autoethnographic* approach, in this case a 'collaborative autoethnography' involving two participants. The distinctiveness of the focus lies in three principal domains. First, the vast majority of research has used professional or elite, young (under-30) male athletes as subjects (eg. Brock & Kleiber, 1994; Young & White, 1995). In contrast, this study is based on the experiences of the author, a middle-aged, female amateur athlete, and her (male) training partner, two non-élite distance runners of basic 'club runner' standard (in UK terminology). Although these runners have a high degree of *commitment* to the pursuit of distance running, according to norms prevailing in the British running subculture, both runners fall within the non-élite category, that is those who stand 'no realistic chance of winning or being highly placed in any category within a race' (Smith, 2000: 188).¹

¹ For an interesting discussion of the categorisation of runners, see Smith (1998).

Second, much research focuses upon athletes unable to attain their pre-injured sporting status, (Sparkes, 1996, 1998; Brock & Kleiber, 1994; Young & White, 1995), whereas this study charts the successful transition from injured sporting body to the rehabilitated state. Third, many recent qualitative studies are based on interviews with injured athletes (Brock & Kleiber, 1994; Sparkes, 1998) or recounting the researcher's own experiences of sport injury and rehabilitation (Sparkes, 1996, 1999; Sparkes & Silvennoinen, 1999) *post hoc*. While both of these approaches rely largely upon the *recollection* of events some time after their occurrence, this study involves data collection during the actual post-injury process; a perspective that appears to be under-represented in the literature. Moreover, Hall (1996) has signalled the need for more studies of women athletes' experiences of sport, this paper responds to that call. Before analysing some of the spectrum of emotions encountered during the process of injury and rehabilitation, it is first necessary to situate the author/researcher within her biography of running, briefly to describe the injury event and subsequent rehabilitative programme, and also to describe the autoethnographic approach adopted.

Biographical and injury context

In order to contextualise the events to be described, it is first necessary to render visible some 'accountable' knowledge (Stanley, 1990), to situate the researcher/author within her biography of running, and to give some biographical information about her running partner and co-researcher. In common with Granskog (2003: 48), my definition of self has at least three critical components, as relevant to this discussion, they are: being a woman, a distance runner and a feminist sociologist. In terms of 'identity salience' (Stryker, 1987), being a running-woman plays a central role in my life. The category of 'woman' has of course long been debated and problematised within the feminist literature (see for example, Wittig, 1981), and the potential of women's sports to transform our 'ordinary sense of what constitutes a gendered body' (Butler, 1998: 104) has been highlighted. Although there is not

the space within this paper to consider the impact of distance running upon my gendered body and my gendered identity, a brief consideration of the gender dimensions of pain and injury may be helpful.

The gender dimensions of the injury experience have been documented in relation to various sporting activities, predominantly at elite level (eg. Young & White, 1995; Young *et al.*, 1994). In relation to this study, although there were undoubted differences between myself and my male running partner in our experiences of, and responses to our knee injuries, detailed analysis of the data did not suggest that gender was a *significant* variable in this particular case. The reasons for this are interesting to unravel. It has been suggested for example that female athletes adopt a 'masculinist' model of sports participation which valorises a 'no pain, no gain' approach analogous to those of male counterparts (Charlesworth & Young, 2003). In relation to other research, some caution is needed with regard to somewhat essentialist constructions of 'masculine' and 'feminine' practices and attitudes. What is considered gender-appropriate behaviour is highly fluid and context-dependent, and perceptions of women as more pain-enduring and stoic than men are also widespread (Bendelow & Williams, 1998). Although running is not usually construed as a high-injury or dangerous sport, pain and injury are nevertheless routine and normalised features within the distance-running subculture, for both sexes, as in other sports such as rowing (Pike & Maguire, 2003) where risk-taking and tolerance of pain and injury were endemic amongst women. As Young & White (1995) also found in their research on elite female athletes, if there is a difference between the way in which female and male athletes appear to understand pain and injury, it is only a matter of degree.

In terms of the distance runner component of my self-definition, now in my mid 40s, I have been a

'veteran' runner for almost a decade, in terms of the UK categorisation system. My current running partner is also a veteran runner, now in his late 50s, and a sociologist. Collectively we have a background of distance running which ranges from 5-mile races to marathons. This has required a commitment to training 6 or 7 days a week, for some periods twice a day, for 18 years (in my case) and 37 years respectively. Moreover, we have trained together - if not continuously, then certainly on a regular basis, for the past 17 years. Our involvement in this activity conforms to Stebbins' (2001) concept of 'serious leisure', involving considerable personal effort, knowledge and training. We identify strongly with the role of distance runners, and interact with others who display a similar level of commitment to the activity (Robbins & Joseph, 1980). We no longer run to win races or to achieve a high ranking, and although acknowledging that, in common with many running colleagues, we: 'regularly (run) further and faster than fitness for health would demand' (Smith, 2000: 190), nevertheless we run primarily for the psychological and physical health benefits. We are, in Stebbins' (2001) formulation, 'amateur devotees'.

At the time of incurring the specific injuries, we were training six days a week, for at least an hour a day, in the evening after work. By strange coincidence, the same windswept November week, we both suffered knee injuries, occasioned by having to train in the winter dark. On the Tuesday, I stumbled into a branch, twisting my right knee forcibly, and on the Friday, my partner slipped badly on a mud patch, wrenching his left knee. A few days following the onset of the injuries, it became apparent that they did not constitute the usual minor problems which plague the habitual runner. At that point we arrived at a collective decision systematically to document our responses to these injuries, a principal motive being to achieve something positive out of what threatened to be a highly negative experience. In this sense, it was one of those unhappy 'accidents of current biography' which provided access, physical and psychological, to the research setting (Lofland & Lofland,

1995, p. 11) and stimulated the joint study. Had only one of us encountered traumatic injury at that point, it is debatable whether we would have actually decided to undertake the research.

Autoethnography

Although not enjoying the more established tradition of its positivistic counterpart in the study of sport (Sparkes, 2002), sports *ethnography* now has a developing body of literature (see for example, Donnelly, 2000; Sands, 2002). Autoethnography is a relatively innovative variation of this ethnographic approach and has in many ways challenged the epistemological foundations of much social scientific investigation (for a detailed discussion, see Sparkes, 2000). A wide range of autoethnographic studies now exists (eg. Reed-Danahay, 1997; Ellis & Bochner, 2000; Sparkes, 2000), and the term itself is usually credited to David Hayano (1979).

Arising from the 'crisis of representation' (Sparkes, 1995) in social science, autoethnography can be viewed as one of the reactions to the 'realist conception of validity' (Hammersley, 1992: 2) which, according to Denzin (1992: 20), seeks to 'privilege the researcher over the subject, method over subject matter, and maintain commitments to outmoded conceptions of validity, truth, and generalizability'. Autoethnography is often distinguished from autobiography by its focus not primarily on the writer, but on specific experiences within her/his life which aim to illuminate wider cultural or subcultural aspects, whilst avoiding solipsism (Greenhalgh, 2001: 51-52). This particular form of investigative process involves the combining of fieldnotes with 'headnotes' (Sanjek, 1990), that is, the researcher's phenomenological experience of engaging with the activity under study. Autoethnographers have sought analytically to 'write themselves into' their accounts of fieldwork as an integral part of the research process. Some ethnographic researchers in sport have seized upon this challenging development and begun to utilise their sporting experiences to produce a range of

autoethnographies or 'narratives of the self' (Sparkes, 2000) relating to various sporting and physical activities (see for example, Sparkes, 2002; 2003; Denison, 1999; Silvennoinen, 1999; Allen Collinson & Hockey, 2001).

Within autoethnographic accounts, the use of particular language forms is designed to convey an immediacy, to make a connection, to *show* the reader the pain and emotions experienced, rather than merely to *tell* what these things meant (see Sparkes, 2003: 65). As Greenhalgh (2001: 55) has noted, there is a degree of risk involved in this genre of 'vulnerable writing', particularly when it focuses on the emotion and pain experienced by the author(s). Writing in this personal and often emotional style challenges the still prevalent taboo of the researcher/author as neutral, distanced, 'silent'. The author may consequently be vulnerable to charges of being 'irrational, particularistic, private, and subjective, rather than reasonable, universal, public, and objective' (Greenhalgh, 2001: 55). As Denison and Rinehart (2000) have recently advocated, however, there is a real need to develop innovative and more evocative ways of writing sociological accounts depicting sporting experience, and this paper represents a response to their call.

All this is not to say, however, that autoethnographic accounts should in any way eclipse other kinds of research tradition, but rather to highlight the potential complementarity of this methodological approach, as being well-placed to provide unique and powerful insights into the phenomenology of injury experiences; experiences which all too often remain private and 'unmarked'. A primary aim of this research project is to construct an account which is evocative, personal and highly reflexive, but also aimed at giving analytical purchase to our autobiographical experiences. In this case, it should be noted that it is actually a 'collaborative autoethnography' in that the data were collected and analysed by two co-researchers/participants, focussing upon both their individual and joint

experiences, including interactional exchanges. Quotations included in this particular paper derive from both of our personal logs (permission granted by my co-researcher). Subsequent to the study, papers have been published both jointly and individually (see for example, Allen Collinson & Hockey, 2001; Allen Collinson, 2003; Hockey, 2004).

The research process

As is common practice among athletes, we kept training logs. Now, instead of training logs we began to construct injury-rehabilitation logs in order to record our engagement with the injured state, and attempts to regain running fitness. Micro-tape recorders were used, both in the field, and where possible at other times; transcription followed as soon as practicable. A joint log, within which analytical themes and concepts were generated, was created via a method somewhat akin to the constant comparative method (Glaser & Strauss, 1967), although less formalized. Thematic or conceptual differences between our accounts were identified and, wherever possible, reconciled, in terms of definition. Where no analytical reconciliation proved achievable, we accepted the difference and recorded it as an atypical case. Subsequently, we explored the reasons for the difference and the impact, if any, upon the process of handling our injuries. In addition, we both sought to act as the 'primary recipient' (Ochs & Capps, 1996) of the other's data, providing regular feedback and critique. This paper is a product of this particular method, and the data, collected over a 2-year period are extracted from the fieldnotes. In both the fieldnotes and the resultant write-up, as noted above, attempts have been made in the spirit of the autoethnographic enterprise to write in a 'personalised' style intended to evoke the climate of feelings at the time. It should, however, be noted that the salience of the emotional aspects of the experience only emerged at the data analysis stage; at the time of data collection we did not anticipate any particular research focus upon our emotions and

emotion work. An examination of some of the most prominent emotions revealed by the data now follows.

Alarm, anxiety and fear

Although well habituated to the routine levels of pain and discomfort engendered by middle/long distance running, for both participants the knee injuries presented a challenge of a different order. Distance running frequently entails a high degree of dys-ease, or Zatopekian pain in Howe's terminology (2004: 152). A subcultural tendency to normalise pain has been noted in the literature regarding a range of activities, not only contact sports (Curry & Strauss, 1994; Nixon, 1993; Pike & Maguire, 2003). As a 'serious runner' (Smith, 1998: 181), one comes to normalise a certain level of discomfort and pain; it has to be tolerated in order to run the distance. As Wiese-Bjornstal *et al* (1998: 63) note: 'athletes learn to define sacrifice, risk, pain, and injury as the price one must pay to be a true athlete in competitive sports' and this can be extended to non-competitive sports and physical activity when undertaken as 'serious leisure'. The knee pain, however, was a totally different phenomenon, in no way construed as 'positive pain' by either participant.

During the first month post injury onset, the pain increased noticeably and both injuries failed to respond to the new, reduced training regimen. Incrementally the injuries began to affect other routine activities: walking, sitting and even sleeping were disrupted by the pain, as a fieldnote indicates:

Well, that's just great – can't even get up or down a small flight of stairs without having to stand with both feet on one stair at a time. What an old 'lady' I am becoming. We've both

started putting cushions between our knees at night in order to take the pressure off them when we sleep. (Individual Log 2)

Such frustration with the 'incapacitated' body has been noted in a variety of contexts, where a person's body is unable to function effectively in everyday, taken-for-granted situations. Moss (1992) for instance notes similar 'incapacitation' in relation to obesity and stair-climbing.

Eventually, with reluctance we were forced to concede that even the reduced level of training was deleterious, producing habitual swelling and intense pain. Individually and collectively we reached a nadir. When one of us observed the other wince or grimace, s/he was beset by emotions: anxiety, alarm, fear, and also frustrated by feelings of impotence, unable to proffer effective help. Frustration was intense at this point, for all attempts at self-directed rehabilitation were proving fruitless. In desperation, and with mixed feelings, a last resort was agreed: the medical profession.

Optimism, relief and doubt

Up to this point, a range of self-help literature for sports injuries had been consulted, but found to be inadequate and often contradictory. Although we were too injury-experienced and realistic to pursue any miracle cure, we set out to find a sports medicine expert, although previous experience of engagement with sports medicine professionals, and indeed the medical profession in general, had been chequered to say the least. As Greenhalgh (2001) vividly recounts, the quest for the 'right' medical practitioner can be highly emotionally-charged, as can the quest for a proper diagnosis (see for example Frank (1991; 1997). After careful research, a local sports injuries clinic was selected. Relief was the overriding emotion at that point, and with cautious hopes of a productive outcome, a climate of quiet optimism pervaded. Unfortunately, despite the use of various physiotherapy

modalities and remedial exercises, our knees failed to improve to any perceptible degree.

Emotions consequently fluctuated as we struggled to maintain individual and collective optimism, morale, and confidence in the therapist.

Toward the end of the series of sessions, our confidence began to wane, doubt crept in, and trust in the physiotherapist became increasingly difficult to sustain, as the injuries were very evidently not improving and pain was still a constant companion. Most disconcertingly, during one of the latter treatments, in an attempt to gauge progress the therapist instructed the performance of a certain form of squat, despite my vocalised concerns. The movement produced a rapid setback in progress and an enormous increase in pain which persisted for several weeks. Subsequently, the physiotherapist started communicating doubts that the knee conditions were within her expertise, and recommended a national centre of excellence with a record of success in the treatment of knee injuries. By this point, I had consulted a range of therapists, including a General Practitioner specialising in sports injuries, various sports physiotherapists and an osteopath, all of whom had offered different diagnoses, ranging from chondromalacia patellae, pre-patellar bursitis, plica, and osteoarthritis, to injuries of the tibial tubercle, the menisci, or the medial ligament, respectively. I had received a 10-week course of physiotherapy treatment, employing a range of modalities, mainly ultrasound and diathermy, intensive remedial exercises designed to strengthen primarily the vastus medialis, and the application of support taping.

Faith, hope and disappointment

At this point the best option appeared to be to proceed with the medicalised pathway. Sustaining this logic and hope was difficult, however, and we had to work particularly hard to justify pursuing the medical quest, given the expensive fees for private consultation and treatment. Within the British

National Health Service there are few resources for sports injury treatment, and the low quality of treatment has obliged many non-professional sports participants to pay for private health services (Joyce, 2001; Howe, 2004). Although both I and my training partner hold full-time jobs, the cost of private health care insurance in the UK is unaffordable for us, and so we use private health practitioners such as physiotherapists and sports therapists on an infrequent, pay-per-visit basis. I count myself fortunate in having sufficient resources to pay for any private health care; for those in low-paid jobs or unemployed, the costs are prohibitive. It was therefore a measure of our desperation that we had been driven to consult private sports clinicians, and to attend a private 'Centre of excellence', which housed a magnetic resonance imaging (MRI) scanner.

With the benefit of emotional distance and analytic hindsight, the encounter with the orthopaedic consultant at the Centre was interesting. Having summarily discounted the diagnoses of other health care practitioners, his cursory physical examination of our injured knees was followed speedily by the forceful proposal of an exploratory operation. The rapidity of this engendered a high degree of unease as both I and my partner had expected a much more rigorous and considered examination, with the MRI scan as first line of diagnosis. Despite considerable pressure from the consultant, we resolutely opted for the MRI scan. Emotions at this time oscillated between anxiety and excitement, with a spectrum in between:

Sitting in the *inner sanctum*, with the knee immobilised and encased in a strange apparatus within the scanner, which hums incessantly. I must keep the knee still at all costs – for a full hour – and I'm anxious to do the right thing. The technician is friendly but concentrates on his console, monitoring the machine, watching the screens, giving nothing away. I can just glimpse some of the images out of the corner of my eye. Strange to think that those dark,

inner, secret, recesses of my body will soon be graphically illustrated. A sense of excitement fills me, but also nervousness. What will be revealed? (Individual Log 2)

We returned in hope to the consultant's office, but to our amazement and disbelief, he indicated his inability to arrive at any sort of diagnosis on the basis of the scanner images. For several moments we sat, emotions in turmoil, shocked, hopes fragmented. Despite all combined efforts to elicit something more substantive, nothing but vague comments emerged. Shock and desperation turned to anger. Now somewhat suspicious of the consultant's motives, we both rejected his insistence upon an exploratory operation, at greater expense. Retreating into shocked disbelief, and in common with many other patients (see for example Greenhalgh, 2001: 75), we tried valiantly to undertake the necessary 'face work' (Goffman, 1967) to hide our anger and dismay, and to exit the room with relative calm.

Despair, anger and blame

Once backstage (Goffman, 1959) in the car on the weary return journey, a vitriolic tirade erupted, and was regularly reprised over the next few weeks as deep disillusionment, deflation, despair, but also resolute fury engulfed us. Primarily our anger and frustration were directed at the medical profession for their ineptitude, but a good deal of fury was also self-directed, due to our misplaced trust, once again, in the medical profession despite long experience of frustrating and inadequate medical encounters and interventions.

Such frustration has been well documented in the literature, and sports participants who sustain injuries through their sporting activity often encounter negative and uncaring attitudes, receive scant or reluctant attention and little or no sympathy from General Practitioners or emergency room staff

(Howe, 2004: 98) who perceive such injuries as in some way self-inflicted. The literature is replete with narratives of the inadequate and inappropriate treatment of athletes at the hands of medical practitioners and the resultant iatrogenic injury and suffering. The contra-indications and side-effects of many popular treatment modalities, such as ultrasound and steroid injections, often remain undisclosed to sportspeople, as noted:

One of the most depressing features of sports medical practice is the frequency with which patients have the severity of their injury increased by the use of these and other forms of treatment (Howe, 2004: 99)

The intense anger at the clinicians and at our own naiveté did, however, have its positive aspects, for it was this anger which propelled us out of the despondency generated by failed medical encounters.

Anger, empowerment and momentum

Anger and frustration with the inadequacies of the medical system made us all the more determined not to lose the connection with the past, and with decades of running. Impelled by anger, we both decided to seize some control, and to escape the intense discomfort of the liminal injured state (elaborated below). Feelings of empowerment developed from this point onwards as we began to chart our own paths to recovery. It was agreed to make every effort to retain the discipline of training for the usual hour each day, initially devoted to walking, then very gradually incorporating more running within the session. This hour, as had always been the case, was hard-won, fought for against the competing demands of work, family, friends, and other social commitments.

A further discipline was also sustained in the form of the usual dietary regime, which we continued to follow rigorously. The link between diet, sport and exercise is highly salient in regard to the athlete's relationship with her or his body and self-concept (Pike & Maguire, 2003: 240) and we certainly made strenuous attempts to maintain this link, although this required a good deal of willpower when confronted by persistent cravings for comfort food of all varieties. It was a struggle to maintain this particular 'government of the body' (Turner, 1991: 160). In recompense, the continuation of our usual disciplined practices provided a sense of control, generated hope and played a fundamental part in re-establishing positive self images, as noted in one of the logs:

... it's 4 months since we have run... neither of us has put on any extra weight, so whilst at the moment we can't run or even jog, we still look like distance runners. That helps because I can still see myself in the mirror and not someone else... I know I can't run at the moment ... but it looks as if I am still running. That's comforting because objectively I know when I start running again the experience will not be as hard as if I were carrying surplus poundage. More importantly, I feel I am still here. I can see my running self. So because I still look like I can run, the possibility is I will eventually. That gives me real hope. (Individual Log 1)

Our somatic forms thus remained almost the same as pre-injury, as a result of diet and the new remedial exercise regime. Our presentation of self (Goffman, 1959) to others and to ourselves consequently corresponded with that of distance runners. In addition, the self-images we held, which included the tried and tested fortitude to endure, were sustained by our continued involvement in, and commitment to, the rehabilitative programme. We not only *looked like* runners, we also *acted like* runners by persevering and sustaining momentum, despite encountering regular bad patches on

the road to recovery. To cut short a long, and sometimes painful and frustrating story, we each subsequently began a very cautious self-devised programme of rehabilitation, the completion of which took both of us in excess of two years. Eventually, after faithfully following each of our programmes of careful, controlled progressive overloading (Sleamaker & Browning, 1996) of the knees, both of us were successful in returning to full running fitness and resuming our pre-injury training mileage on a regular basis.

While there was some degree of linearity, albeit fragmented, to this process, there also existed a certain circularity. At times our knees would suddenly deteriorate, sometimes capriciously for no discernible reason, and we would find ourselves propelled down what we termed the 'time-tube' to experience again a deluge of emotions: fear, anger, despair:

Cold, rainy evening. Still maintaining the 5-mins (of running) with 5-mins walking in between. Going absolutely fine, then suddenly the knee completely gave way in the second. No rhyme or reason. Too tired/despondent to write much. Just feel grey. Very frightened. Am I back at square 1? Or is this just a temporary set-back. The old fear is back. Feel like giving up right now. Tomorrow I won't? (Individual Log 2)

Over the two years, being flung 'back in the time-tube' and travelling this circular experiential loop became familiar phenomena. In stark contrast to the smooth transition between states of body and stages of experience, as sometimes portrayed in the sports injury literature, the rehabilitative progress was faltering, jolting, fragmented, and our emotions oscillated correspondingly. Intense emotions and emotional oscillations were a significant feature of the injury and rehabilitation process,

and required careful personal management, sometimes achieved only with great difficulty, as outlined in the following sections.

Pain, injury and emotions

Although much of the sociological literature on emotions emphasizes the need analytically to transcend Cartesian dualistic thinking in order fully to understand emotion, one of the principal ways in which we coped with our knee injuries and the resultant pain, was precisely via the objectification of the affected body parts and the pain itself. Such objectification has been noted in the sociological literature with regard to a range of 'normal', 'abnormal' and 'sick' bodies, for example in relation to women's breasts (Young, 1992), obese bodiwa (Moss, 1992; Gapinski *et al*, 2003), and the body with multiple sclerosis (Toombs, 1992). In relation to the pain experience, Leder (1990: 73-74) notes how the painful body 'emerges as an alien presence' and becomes a thing to which a person must attend. In our own case of relatively minor suffering, emotions were directed at our bodies, and in particular at 'the knees': anger, irritation, frustration, despair. Our attention was repeatedly drawn back to that particular body part, to *here* instead of *there* (Honkasalo, 1998: 43). The following field note, indicative of many, reflects such objectification:

Today we went for a little walk on the Malvern Hills, and included a short stretch of walking long ways across a sloping field. Didn't experience any great problem at first, but then the knee became increasingly painful. J noticed my grimacing and we immediately decided to get off the slope as quickly as possible. Probably set me back days, may be weeks and I'm so ANGRY. The thing must be so weak and fragile, it can't even take a little slope! What's happened to my legs? They were so tough and strong and now even the tiniest incline is too much for them. They've betrayed me, let me down. Feel like an old lady. (Training Log 2)

We railed against 'the knees' and their stubborn refusal to function effectively; we were grounded, metaphorically and physically. This mind-body dualism has been described vividly in the literature relating to the suffering of chronic pain (see for example, Jackson, 1994). Such an approach may help individuals to achieve some distance on the injury experience and thereby to control their emotional response. In our case, we attempted to regain some control by adopting a more 'objective' and detached perspective. This also corresponded to the mode adopted by health care professionals consulted at various points in the rehabilitation process, all of whom referred to the injured body part as an entity separate from the person in which it was situated. This tendency for the medical profession to reinforce the objectification of the body has been well documented (see for example, Moss, 1992), with patients frequently critiquing their depersonalisation, even dehumanisation at the hands of medics who treat them: "...like 'a piece of meat', or another 'interesting case': poked, prodded, examined, tested, diagnosed, medicated, but not treated as a *person* with respect and consideration." (Leder, 1992: 1; italics in original). It should be noted, however, that there exists a strong countervailing perspective on the experience of pain as *transcending* mind-body dualism (eg. Jackson 1994).

In addition to the pain, we also had to contend with the rapid fluctuations in emotional state which occurred during the injury and rehabilitation process, and which have been noted in the sports injury literature, particularly accounts aimed at healthcare professionals (see for example, Crust, 2003). With reference to a poignant and life-threatening situation, these rapid shifts in emotion were evocatively documented by Rosenblum (1990), discussed in Hepworth (1998:174), as the former reflected upon her own approaching death from cancer and the turbulence of her emotions. Although clearly far from such an extreme life situation, these emotional oscillations, sometimes quite violent, certainly figured in our experience. The following extract refers to the previously cited instance when a physiotherapist instructed the performance of a certain form of squat.

Went into the physio's today, positive and cheerful. Unfortunately, in her wisdom, she decided to 'test' my progress by making me do a squat... Didn't even attain the full squat position when I felt the knee suddenly give way, snap, break, grind – whatever. Horrible, shooting, stabbing, crunching, gritty pain. Shocked in to silence. I look around for something with which to pull myself up and out of the pain. I'm stuck for what seems forever. An age passes before J comes across the room to help me up. Burning hot, liquid rage engulfed me. How did I manage not to attack her? [...] But by the time I got to the door of the clinic, all I felt was deflated, totally deflated, despair. Red heat turned to cold, dark grey.

(Individual Training Log 2)

In this instance, emotions were experienced immediately and strongly, and yet the norms of the social situation required that these violent emotions be managed, contained and rendered acceptable in the 'impersonal' public world (Lupton, 1998). Although not recorded in the fieldnotes, I

recall vividly that despite an almost murderous intent, I did muster sufficient self-control to proceed with the remainder of the physiotherapy encounter, and to exit the field without, I think, betraying in any way my utter fury to the person who had provoked such a response.

Emotion work and intersubjectivity

James (1989: 15) has defined emotional labour as ‘the labour involved in dealing with other peoples’ feelings, a core component of which is the regulation of feelings’. Hochschild (1983: 7), however, makes a useful analytic distinction in employing the term *emotional labour* with regard to paid labour, where there is: ‘the management of feeling to create a publicly observable facial and bodily display; emotional labor is sold for a wage and therefore has *exchange value*’ (italics in original). In contrast she uses the terms *emotion work* or *emotion management* to refer to acts carried out in a private context where they have *use value*. For the purposes of this paper, I use the term emotion work to refer to the management of feelings in ‘private’ interactional contexts with my training partner.

Although the concept of emotion work has been criticised by some (eg, Bendelow & Williams, 1998: 211) for its over-simplification of complex mental processes such as ‘repression’ and ‘denial’, it has been utilised in the sociological literature, and provides a useful device. Such emotion work certainly constituted a salient component of our injury and rehabilitation process, particularly during periods when individual emotional states diverged, for instance when one of us encountered a sudden regression in performance and consequently experienced a raft of negative emotions. At such times, the other partner, who was making more positive progress, experienced a kaleidoscope of shifting emotions, including sympathy and empathy, anxiety, anger that the other should have to endure more difficulties, and sometimes guilty relief that s/he wasn’t suffering in the same fashion.

Of significance at these times was the perceived need to manage and regulate our own personal feelings so as not to compound the other's problems, perhaps by providing too stark and visible a contrast in feelings about the current situation and performance levels. As Lupton has noted, emotion work is: '... not merely about stifling or suppressing feeling, but also about constituting feeling, bringing it into being in response to awareness of social norms about what one *should* be feeling' (1998: 19; emphasis in original). Thus, emotion work requires not just the repression and disguise of emotions, but also their expression, which may involve what Hochschild (1983: 42 et seq.), following others, has termed everyday 'deep acting', our attempts actually 'to feel what we sense we ought to feel or want to feel'. This she contrasts with surface acting, the deliberate, contrived, 'put on', outward display of emotions. Deep acting, on the other hand, produces a more 'genuine' outward display via the generation of actual feeling which has been self-induced by the social actor. In surface acting the actor experiences the emotional display as put on, not 'part of me' - in deep acting the actor actually experiences the emotions as authentic.

With regard to our own experiences of emotion work, we utilised techniques of both surface and deep acting, but in subsequent analysis of the fieldnotes, it emerged that deep acting constituted the principal method for both of us. A prime example of this would occur when the relatively healthy partner might be experiencing relief or even happiness because her/his own rehabilitative session was proceeding well. However, upon perceiving that the other was in difficulty, s/he would deduce that her/his own feelings were not appropriate to the current social situation (Hochschild, 1979: 563) and therefore strive to regulate those feelings in order to offer genuine sympathy and support to the other person. At various points, each of us felt that it would have been inappropriate, even reprehensible, to express certain positive feelings about our own performance in front of the other, if these feelings were deemed to be too divergent from the current negative experience of the other. We utilised our own 'emotion memories' (Hochschild, 1983) in relation to previous injuries, both sporting and non-sporting, to imagine and to empathise with the feelings of the other, and to construct collective narratives to support the sufferer.

The extracts below are taken from the individual logs and illustrate each participant's response to the same incident when one partner endured an acute set-back and the other sought to regulate her own emotions in order to offer support:

J has just had a really difficult run. We attempted a very small incline for the first time, just to test the knees a little to see if they would cope with the slope... then suddenly J had a vicious, stabbing pain in his knee which forced him to pull up immediately. Understandably furious... Really concerned about J, he was obviously in pain, absolutely livid and it could have set him back weeks... Tried to be sympathetic, but also calming and supportive and positive. Took all my energies, but I know just how he feels. (Individual Log 2)

The analogous field note relates:

Yesterday evening we had a bad patch... We negotiated a small pitch both up and down, everything seemed ok, until about 50 yards on my knee began to STAB me very sharply... I pull up quickly taking the weight on my good leg, full of dread. I sit on the ground and explode with frustration, furious expletives darken the air repeatedly. J comes over quickly to give me support. I berate my knee, I berate our decision to add in the pitch to the programme... My frustration bubbles over as I glance at the micro tape recorder in her hand: "Don't you dare turn that ****ing thing on!" (Individual Log 1)

Goffman's notion of 'flooding out' is relevant:

'... under certain circumstances the individual may allow his manner to be inundated by a flow of affect that he no longer makes a show of concealing ... and he collapses, if only momentarily, into a person not mobilized to sustain an appropriate expressive role in the current interaction; he *floods out*'. (1972: 50 et seq.; emphasis in original)

It is questionable whether the explosion of rage from my training partner could be defined as not constituting an 'appropriate expressive role' in the context. For my part, I defined the reaction as perfectly understandable and context-appropriate, knowing full well that I would have reacted in an analogous way. However, the sudden overwhelming experience and outpouring of emotion does have inundatory qualities, and the verbal violence of the response certainly did result in a radical alteration of my partner's general support of the interaction.

At such times, the degree of emotion work required was considerable, for, as James (1989: 19) has noted, this can be hard work indeed, requiring that the 'labourer' give personal attention and therefore something of her/himself to another, at times when it would have been easier to concentrate on the self. In contrast, however, it is important to acknowledge the rewards and satisfaction that such work can provide. As Sharma and Black (2001) note in relation to their study of beauty therapists, emotional labour and emotion work can also be satisfying. Both my training partner and I considered the mutual offering of support and the emotion work required to do this, to be a central and fundamental component of our running partnership. We expected mutuality and reciprocity in our emotion work, and this constituted an important factor in sustaining the relationship. Not only did we expect each other to empathise with and understand the emotional state of the other, but also, interestingly, we expected a relatively high degree of emotional management and restraint from the other, in order to avoid *over-identification* (Reay, 2000: 574-575) with the other. This might have compromised the provision of helpful support and also generated a welter of additional negative feelings with which we would have been required to contend. As veteran runners and long-standing training partners, we each assumed that the other would have sufficient emotional discipline to manage her/his own feelings, at least for the majority of the time, and to maintain enough emotional distance to provide help and support.

It is interesting to note at this point, perhaps *contra* expectations, that we both considered there to be no discernible gender differentiation in the degree of emotion work undertaken by both parties. This stands in stark contrast with research that demonstrates a strong gender division of labour, where women take primary responsibility for 'doing' emotional labour and emotion work, both in intimate relationships and within the sphere of paid work and volunteering (Duncombe & Marsden, 1998; Hochschild, 1998; Lupton, 1998; Langford, 1999; Lois, 2001; Williams, 2001). The most compelling reason for our divergence from this gendered patterning might be the specific roles we adopted within the running context, situated within our own 'emotional habitus' (Crossley, 1998: 33), developed and refined over many years of co-running. For the purpose of this paper, I define 'the running context' very broadly, as including not only the actual physical activities (training sessions, racing, gym workouts, rehabilitative work, etc), but also the times when training and rehabilitation were discussed between ourselves and with other athletes and friends. Within the running context, we perceived our primary roles as co-runners and training partners. Although undoubtedly a gender dimension was present, this appeared to be largely recessive, far from the forefront of our subjectivities and interaction, and we related to each other first and foremost as co-runners, suffering an analogous injured state, seeking the same return to fitness, and generating similar 'restitution narratives' (Frank's, 1995).

Discussion

The state of being injured and attempting to return to full fitness bore many of the hallmarks of liminality. The concept of liminality, originally defined by van Gennep (1960), and subsequently elaborated by Turner (1969), was employed initially in relation to *rites de passage* involving a transition from a secular to a sacred condition or *vice versa*. This produces a liminal situation; an ambiguous, uncertain state wherein an individual is caught in time (and often space) between a

previous status and a new status yet to be attained. As Brock and Kleiber (1994: 421) have perceptively noted, the injured athlete is subjected to this ambiguous, ill-defined and sometimes invisible condition, portrayed as a transition from a sacred to a profane state.

This 'fall from grace' was felt keenly by both of us, giving rise to an array of emotions ranging from anger to despair, as we struggled to come to terms with the injured state, and to suffer the mortification (Goffman, 1976) of our former 'gloried' (in a minor way) athletic selves (Adler & Adler, 1989; Kleiber & Brock, 1992). In acknowledging the demise, albeit temporary (we fervently hoped), of the running identity, we were forced to recognise and endure 'the loss of a celebrated state and an acquisition of ordinariness' (Brock and Kleiber, 1994: 422). Indeed, in many ways, we were not even physically on a par with 'ordinary' (that is, non-athlete) persons, as gradually even some of the normal, routine physical activities, like ascending stairs, became problematic.

As a consequence of the injury events, both of us were forced to reduce the amount and intensity of running and training, and subsequently to cease running altogether, for a period of time. As noted above, after following the self-devised rehabilitative programmes, both of us were successful after approximately two years in returning to full running fitness and resuming our pre-injury training mileage, and racing. Prior to this resumption, however, enforced 'injury time' (Allen Collinson, 2003) had a highly deleterious impact upon our subjectivities, for as Petrie has noted:

Serious injury is one of the most emotionally and psychologically traumatic things that can happen to an athlete ... Because athletes are so dependent upon their physical skills and because their identities are so wrapped up in their sport, injury can be tremendously threatening to them. (1993: 18-19)

As experienced runners, we both handled the injuries in our own tried and tested individual ways. Some of the *interactional* means by which we coped with the trials and tribulations of the injury process have been examined in the paper, alongside the spectrum of emotions generated. The injury experience can be both isolating and alienating, as the athlete struggles to adjust to her/his liminal position (Brock & Kleiber, 1994), and the importance of social support for injured sportspeople has been well documented (Johnston & Carroll, 2000; Crust, 2003). We were both in agreement that of particular importance in coping with the injury process and subsequently sustaining the momentum to achieve full recovery, was the emotional support and interaction between us. This is of course in many ways an unusual and privileged position, since many sportspeople find themselves isolated in their injury struggles.

A central component of our mutual emotion work was the construction of narratives centred upon the injuries, rehabilitation, and athletic careers in general. Each of us acted as the 'co-teller' for the other (Ochs & Capps, 1996: 31). This involved a good deal of interaction and emotion work and the co-teller role was fundamental to achieving momentum towards recovery (Duranti & Brenneis, 1986). Although one can never claim complete entry into the subjectivity of another, via our narrative exchanges we appeared to achieve a high degree of intersubjectivity. This allowed each person a fully social and emotional voice; a voice which we both understood to be acknowledged in a highly empathetic way. The result of this intersubjectivity and co-telling was that neither of us suffered any significant degree of isolation or alienation during the emotionally-charged liminality of the injured state. Without the active and receptive presence of the other as audience, and the mutual provision of advice and emotional support, it seems likely that the rehabilitation process would have been significantly slower and more problematic. Together we encountered a spectrum of emotions which

oscillated wildly at certain points. We enthused, empathised, sympathised, critiqued, berated, cajoled, badgered, encouraged and motivated each other towards recovery. Undoubtedly, this required intense and sustained *emotion work*, exhausting on many occasions, sometimes frustrating, but also experienced as rewarding and satisfying by both parties.

As Wiese-Bjornstal *et al* (1998) have pointed out, there is a need to enhance the insight and clarity of communication between the injured athlete and members of her/his sports medicine team, to provide a complete picture of athlete emotional states. Although the intensity of the emotion work which my training partner and I provided is unlikely to be a feasible prospect for most health care professionals, nevertheless it perhaps signals the need for sports 'support workers' to take account of, and gain some understanding of the emotional component of the injury process. Future research might therefore profitably examine not only the sportsperson's emotional responses, but also the practical and policy implications of providing emotional support during the injury and rehabilitative process.

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